**Infectious Disease Agents: Antivirals – HIV**

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| Criteria 1 | NP - Abacavir Susp, Abacavir/Lamivudine/Zidovudine, Aptivus, Didanosine, Edurant, Fosamprenavir, Fuzeon, Lamivudine Tab, Lamivudine/Zidovudine, Nevirapine IR, Nevirapine ER Tab, Norvir Powder, Norvir Sol, Stavudine, Stribild, Tybost, Viracept |
| Criteria 2 | NP with AR- Lamivudine Sol, Nevirapine Sol |
| Criteria 3 | Agents with BvG- Efavirenz/Lamivudine/Tenofovir Disoproxil Fumarate, Selzentry, Maraviroc, Intelence, Etravirine, Emtricitabine, Darunavir |
| Criteria 4 | Isentress Chew Tab (P, AR) |
| Criteria 5 | Triumeq PD (P, PA) |
| Criteria 6 | Rukobia ER (P, PA) |

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| **Criteria Title** | Infectious Disease Agents: Antivirals – HIV | | |
| **Criteria Subtitle** | Non-Preferred Products | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| ABACAVIR SUSP | 040965 | GCNSeqNo |
| ABACAVIR/LAMIVUDINE/ZIDOVUDINE | 047121 | GCNSeqNo |
| APTIVUS | 059306 | GCNSeqNo |
| DIDANOSINE | 046738 | GCNSeqNo |
| DIDANOSINE | 046739 | GCNSeqNo |
| EDURANT | 067413 | GCNSeqNo |
| FOSAMPRENAVIR | 053176 | GCNSeqNo |
| FOSAMPRENAVIR | 058365 | GCNSeqNo |
| FUZEON | 068664 | GCNSeqNo |
| LAMIVUDINE TAB | 041033 | GCNSeqNo |
| LAMIVUDINE TAB | 024417 | GCNSeqNo |
| LAMIVUDINE TAB | 049905 | GCNSeqNo |
| LAMIVUDINE/ZIDOVUDIN | 034186 | GCNSeqNo |
| NEVIRAPINE IR, ER TAB | 027467 | GCNSeqNo |
| NEVIRAPINE IR, ER TAB | 067250 | GCNSeqNo |
| NEVIRAPINE IR, ER TAB | 068203 | GCNSeqNo |
| NORVIR POWDER, SOL | 025080 | GCNSeqNo |
| NORVIR POWDER, SOL | 075279 | GCNSeqNo |
| STAVUDINE | 021982 | GCNSeqNo |
| STAVUDINE | 021983 | GCNSeqNo |
| STAVUDINE | 021985 | GCNSeqNo |
| STRIBILD | 069883 | GCNSeqNo |
| TYBOST | 072318 | GCNSeqNo |
| VIRACEPT | 030366 | GCNSeqNo |
| VIRACEPT | 052160 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0997 |  | Select and Free Text | Has the patient taken the drug in the previous 120 days?  If yes, please submit documentation of recent use. | Y | END (Approve x 365 Days) |
| N | 0998 |
| 2 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 3 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 4 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days with at least one preferred drug?  If yes, please submit the medication trials and dates. If applicable, the request must address the inability to use the individual components. | Y | 1002 |
| N | 1001 |
| 5 | 1001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1002 |
| N | 1236 |
| 6 | 1002 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1003 |
| N | END (Approve x 365 Days) |
| 7 | 1003 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Approve x 365 Days) |
| N | 1235 |
| 8 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Approve x 365 Days) |
| N | 1235 |
| 9 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 10 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 8/18/2023 |
| **Other** |  |

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| **Criteria Title** | Infectious Disease Agents: Antivirals – HIV | | |
| **Criteria Subtitle** | Lamivudine Sol, Nevirapine Sol | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| LAMIVUDINE SOL | 041032 | GCNSeqNo |
| LAMIVUDINE SOL | 024418 | GCNSeqNo |
| NEVIRAPINE SOL | 040786 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0997 |  | Select and Free Text | Has the patient taken the drug in the previous 120 days?  If yes, please submit documentation of recent use. | Y | END (Approve x 365 Days) |
| N | 0998 |
| 2 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 3 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 4 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days with at least one preferred drug?  If yes, please submit the medication trials and dates. If applicable, the request must address the inability to use the individual components. | Y | 1002 |
| N | 1001 |
| 5 | 1001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1002 |
| N | 1236 |
| 6 | 1002 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1003 |
| N | 1004 |
| 7 | 1003 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | 1004 |
| N | 1235 |
| 8 | 1004 |  | Select | Is the patient 3 years of age and older? | Y | 1235 |
| N | END (Approve x 365 days) |
| 9 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Approve x 365 Days) |
| N | 1235 |
| 10 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 11 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 8/18/2023 |
| **Other** |  |

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| **Criteria Title** | Infectious Disease Agents: Antivirals – HIV | | |
| **Criteria Subtitle** | Non-Preferred Products with BvG | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| EFAVIRENZ/LAMIVUDINE/TENOFOVIR DISOPROXIL FUMARATE | 078145 | GCNSeqNo |
| EFAVIRENZ/LAMIVUDINE/TENOFOVIR DISOPROXIL FUMARATE | 078254 | GCNSeqNo |
| SELZENTRY | 062974 | GCNSeqNo |
| SELZENTRY | 062979 | GCNSeqNo |
| SELZENTRY | 076850 | GCNSeqNo |
| SELZENTRY | 077086 | GCNSeqNo |
| SELZENTRY | 077087 | GCNSeqNo |
| MARAVIROC | 062974 | GCNSeqNo |
| MARAVIROC | 062979 | GCNSeqNo |
| INTELENCE | 063597 | GCNSeqNo |
| INTELENCE | 066982 | GCNSeqNo |
| INTELENCE | 069091 | GCNSeqNo |
| ETRAVIRINE | 063597 | GCNSeqNo |
| ETRAVIRINE | 066982 | GCNSeqNo |
| EMTRICITABINE | 052802 | GCNSeqNo |
| DARUNAVIR | 063719 | GCNSeqNo |
|  | DARUNAVIR | 070245 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0997 |  | Select and Free Text | Has the patient taken the drug in the previous 120 days?  If yes, please submit documentation of recent use. | Y | END (Approve x 365 Days) |
| N | 0998 |
| 2 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 3 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 4 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days with at least one preferred drug?  If yes, please submit the medication trials and dates. If applicable, the request must address the inability to use the individual components. | Y | 1002 |
| N | 1001 |
| 5 | 1001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1002 |
| N | 1236 |
| 6 | 1002 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1003 |
| N | 1004 |
| 7 | 1003 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | 1004 |
| N | 1235 |
| 8 | 1004 |  | Select | Which medication is being requested? | Generic efavirenz/lamivudine/tenofovir disoproxil fumarate | 1005 |
| Brand Selzentry | END (Approve x 365 Days) |
| Generic maraviroc | 1005 |
| Brand Intelence | END (Approve x 365 Days) |
| Generic etravirine | 1005 |
| Generic emtricitabine | 1005 |
| Generic darunavir | 1005 |
| Other | END (Approve x 365 days) |
| 9 | 1005 |  | Select and Free Text | Has the brand medication been attempted and failed or is the brand medication contraindicated?  If yes, please submit documentation. | Y | END (Approve x 365 Days) |
| N | 1235 |
| 10 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Approve x 365 Days) |
| N | 1235 |
| 11 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 12 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 8/18/2023 |
| **Other** |  |

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| **Criteria Title** | Infectious Disease Agents: Antivirals – HIV | | |
| **Criteria Subtitle** | Isentress Chew Tab | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| ISENTRESS CHEW TAB | 068332 | GCNSeqNo |
| ISENTRESS CHEW TAB | 068334 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 1234 |  | Select | Is the patient 12 years of age and older? | Y | 1235 |
| N | 1236 |
| 2 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 3 | 1236 |  | Free Text | A PA is not required for those younger than 12 years of age. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 8/18/2023 |
| **Other** |  |

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| **Criteria Title** | Infectious Disease Agents: Antivirals – HIV | | |
| **Criteria Subtitle** | Triumeq PD | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| TRIUMEQ PD | 083242 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0996 |  | Select and Free Text | Has the patient taken the drug in the previous 120 days?  If yes, please submit documentation of recent use. | Y | END (Approve x 365 Days) |
| N | 0997 |
| 2 | 0997 |  | Select and Free Text | Has the provider submitted documentation of the patient’s weight?  Please note: This medication will only be authorized for those 10 – 25 kg. | Y | 0998 |
| N | 1235 |
| 3 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 4 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | END (Approve x 365 Days) |
| N | 1235 |
| 5 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Approve x 365 Days) |
| N | 1235 |
| 6 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 8/18/2023 |
| **Other** |  |

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| **Criteria Title** | Infectious Disease Agents: Antivirals – HIV | | |
| **Criteria Subtitle** | Rukobia ER | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| RUKOBIA ER | 081260 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 1234 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | END (Approve x 365 days) |
| N | 1235 |
| 2 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 8/18/2023 |
| **Other** |  |